

CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

"Abuse" means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health.

"Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

"Beginning eligibility date" means date of an individual's admission to the facility or date of eligibility for medical assistance, whichever is the later date.

"Civil penalty" shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

"Clinical experience" means application or learned skills for direct resident care in a nursing facility.

"Denial of critical care" is a pattern of care in which the resident's basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident's serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

"Department" means the Iowa department of human services.

"Discharged resident" means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form AA-4166-0, Case Activity Report.

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes skilled nursing facilities and swing-bed hospitals providing care unless stated otherwise.

"Facility-based" means a nurse aide training program which is offered by a nursing facility and taught by facility employees or under the control of the licensee.

"Informed consent" means a resident's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

"Laboratory experience" means practicing care-giving skills prior to contact in the clinical setting.

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“Non-facility-based” means a nurse aide training program which is offered by an organization which is not licensed to provide nursing facility services.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“Nurse aide training and competency evaluation programs (NATCEP)” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“Physical abuse” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Poor performing facility (PPF)” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

“Primary instructor” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“Program coordinator” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“Skills performance record” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“Terminated from the Medicare or Medicaid program” means a facility has lost the final appeal to which it is entitled.

“Testing entity” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“a,” and 249A.4.

441—81.2 Rescinded, effective 11/21/79.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Certification of need.* Residents of nursing facilities shall be certified as needing either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Foundation for Medical Care.

81.3(2) *Skilled nursing care level of need.* Payment will be approved for skilled nursing care in Medicare-certified beds under the same conditions as the Medicare program in nursing facilities. Nursing facilities which are Medicare-certified as skilled nursing facilities are eligible for skilled level payment for care provided to Medicaid recipients who require skilled nursing care.

Nursing facilities providing skilled nursing care which serve a disproportionate share of Medicaid recipients who are not Medicare-eligible shall be eligible for Medicaid skilled level payment and are not required to be Medicare-certified. These facilities must meet Medicare-certification requirements. In-state facilities must be certified as meeting Medicare requirements by the department of inspections and appeals. Out-of-state facilities must also be enrolled Medicaid providers in their state.

In order for a nursing facility to be eligible for Medicaid skilled level payment, the facility must be certified for participation in the Medicare skilled nursing program, the resident must require skilled level care, and, if applicable, Medicare care benefits must be exhausted.

a. Exceptions to the Medicare policies are as follows:

(1) Medicaid does not limit the number of days in skilled care as long as the services are medically necessary.

(2) Medicaid does not require that the person be previously hospitalized.

(3) Respite care for recipients eligible for the home and community-based services program. (See 441—Chapter 83.)

(4) Payments may be allowed with advance approval for a facility to reserve a bed for a resident while the resident is absent overnight for home visits or for participation in special social or rehabilitation programs. Approval shall be received prior to the absence and shall be requested by sending a letter to the division of medical services giving the purpose for the absence and stating that the following conditions are met:

1. The resident or the resident's representative chooses to have the resident leave the facility for this purpose.

2. The family members or agency responsible for providing the alternative care can and will provide the care and make no charges to the department for the care.

3. The absence is approved in the physician's plan of care.

4. The facility provides the usual medical equipment and supplies needed by the resident.

Periods of paid absence from a skilled nursing facility shall not exceed 10 consecutive calendar days at a time with a maximum of 18 days in a calendar year and shall be available only after a resident has required care in a nursing facility or a skilled nursing facility for at least three consecutive months. Payments for periods of approved absence shall be made at 75 percent of the regular Medicaid rate.

(5) Payments may be allowed with approval prior to billing for a facility to reserve a bed for a resident while the resident is absent overnight for hospitalization if the resident has required care in a nursing facility or a skilled nursing facility for at least three consecutive months. Periods of paid absence from a skilled nursing facility shall not exceed ten days in any calendar month. Payment will not be authorized for over ten days for any continuous hospital stay whether or not the stay extends into a succeeding month or months. Payments for periods of approved absence shall be made at 75 percent of the regular Medicaid rate.

b. Nursing facilities providing skilled care in other states are also eligible for skilled level payment if the placement is approved by the department. Requests for payment shall be submitted to the Division of Medical Services, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. Payment will be approved for out-of-state skilled nursing facility care when the following criteria are met:

- (1) The facility is eligible to participate in the Iowa Medicaid program.
- (2) The facility has been certified for Medicare and Medicaid participation by the state in which the facility is located.
- (3) The placement is recommended because moving the resident back to Iowa would otherwise endanger the resident's health, services are not readily available in Iowa, or the out-of-state placement is cost-effective.
- (4) The placement is temporary until services are available to the resident in Iowa or the program of treatment is completed.

81.3(3) Screening. All persons, regardless of the source of payment, seeking admission to a nursing facility shall also be screened by the Iowa Foundation for Medical Care to determine if mental illness, mental retardation, or a related condition is present. The Iowa Medicaid program will cover the cost of this screening through the managed mental health contractor.

Final approval for initial admissions and continued stay of persons with mental illness, mental retardation, or a related condition is determined by the department of human services, division of mental health, mental retardation and developmental disabilities.

Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the division of mental health, mental retardation and developmental disabilities that the person's treatment needs will be or are being met.

Adverse decisions made by the Iowa Foundation for Medical Care (IFMC) in administering either level 2 or level 3 of the screening process shall be appealed first to IFMC for reconsideration. An adverse reconsideration decision by IFMC shall then be appealed to the department pursuant to 441—Chapter 7.

81.3(4) Special care level of need. Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“a” and 249A.4.

441—81.4(249A) Arrangements with residents.

81.4(1) Resident care agreement. Rescinded IAB 12/6/95, effective 2/1/96.

81.4(2) Financial participation by resident. A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5)“c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)“a,” and 249A.4.

441—81.5(249A) Discharge and transfer. (See subrules 81.13(2)“a” and 81.13(6)“c.”)

81.5(1) Notice. When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator shall promptly notify the local office of the department. This shall be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge.

81.5(2) Case activity report. A Case Activity Report, Form AA-4166-0, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility’s records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician’s orders for care.
- f. The resident’s personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.5(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident’s client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)“a,” and 249A.4.

441—81.6(249A) Financial and statistical report. All facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form AA-4036-0, to the department. Costs for patient care services shall be reported, divided into the subcategories of “Direct Patient Care Costs” and “Support Care Costs.” Costs associated with food and dietary wages shall be included in the “Support Care Costs” subcategory. An electronically submitted cost report shall be accepted if the format is approved by the accounting firm under contract with the department to audit nursing facility cost reports. These reports shall be based on the following rules.

81.6(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

81.6(3) Submission of reports. The report shall be submitted to the department no later than three months after the close of each six months’ period of the facility’s established fiscal year. Failure to submit a report that meets the requirements of this rule within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the department 60 days prior to the first date of the change.

81.6(4) *Payment at new rate.* When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

81.6(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be included in each six-month report in equal amounts. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) *Census of public assistance recipients.* Census figures of public assistance recipients shall be obtained on the last day of the month ending the reporting period.

81.6(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

- c. Bad debts are not an allowable expense.
- d. Charity allowances and courtesy allowances are not an allowable expense.
- e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.
 - (1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).
 - (2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.
 - (3) Each facility which supplies transportation services as defined in Iowa Code section 601J.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 601J and 820—[09,A] chapter 2 of the department of transportation rules at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division shall, result in disallowance of vehicle costs and other costs associated with transporting residents.
 - (4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.
 - (5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.
 - (6) Travel for which a patient must pay is not an allowable expense.
 - (7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.
- f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.
- g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.
- h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

* (4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates as defined by subrule 81.6(16) "a."

* (5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

* (6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

i. Management fees shall be limited on the same basis as the owner administrator's salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

*Objection imposed 9/11/89, see Objection 81.6(11) "h" (4), (5), (6) at end of chapter.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs following the decertification date.

81.6(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) *Facility-requested rate adjustment.* A facility may not request a rate adjustment for a period of time more than two years from the date of the request.

81.6(14) *Payment to new facility.* A new facility for which cost has not been established shall receive the prevailing maximum allowable cost ceiling. At the end of three months' operation, a financial and statistical report shall be submitted and the cost established. Subsequent reports shall be submitted from the beginning day of operation to the end of the fiscal year or six months' interim period, whichever comes first, and each six months thereafter.

81.6(15) *Payment to new owner.* An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established, not to exceed private pay charges. The facility may submit a report for the period from beginning of actual operation to the end of the fiscal year or may submit two cost reports within the fiscal year provided the second report covers a period of six months ending on the last day of the fiscal year. The facility shall notify the department of the date its fiscal year will end and of the reporting option selected.

81.6(16) *Establishment of ceiling and reimbursement rate.*

a. An inflation factor will be considered in determining the facility's prospective payment rate. The rate will be determined by using the change in the weighted average cost per diem of the compilation of various costs and statistical data as found in the two most recent reports of "unaudited compilation of various cost and statistical data." The percentage increase of this weighted average will be the basis for the next semiannual inflation factor. The inflation factor shall not exceed the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31, on an annual basis.

b. An incentive factor shall be determined at the beginning of the state's fiscal year based upon the June 30, 1986, "unaudited compilation of various costs and statistical data." The incentive factor shall be equal to one-half the difference between the forty-sixth percentile of allowable costs and the seventy-fourth percentile of allowable costs. Notwithstanding the foregoing, under no circumstances shall the incentive factor be less than \$1 per patient day or more than \$1.75 per patient day.

c. For non-state-owned nursing facilities, the reimbursement rate shall be established by determining, on a per diem basis, the allowable cost plus the established inflation factor plus the established incentive factor, subject to the maximum allowable cost ceiling.

d. For non-state-owned nursing facilities, an additional factor in determining the reimbursement rate shall be arrived at by dividing total reported patient expenses by total patient days during the reporting period. Total patient days for purposes of this computation shall be inpatient days as determined in subrule 81.6(7) or 80 percent of the licensed capacity of the facility, whichever is greater.

e. Effective January 1, 1998, the basis for establishing the maximum reimbursement rate for non-state-owned nursing facilities shall be the seventieth percentile of participating facilities' per diem rates as calculated from the December 31, 1997, report of "unaudited compilation of various costs and statistical data."

Beginning July 1, 1998, the basis for establishing the maximum reimbursement rate for non-state-owned nursing facilities shall be the seventieth percentile of participating facilities' per diem rates as calculated from the June 30, 1998, report of "unaudited compilation of various costs and statistical data."

f. The per diem rate paid for skilled nursing care provided by a nursing facility certified under the Medicare program shall be established according to guidelines in 441—subrule 79.1(9).

g. Facilities, both hospital-based distinct units and freestanding, which have beds certified as Medicare-skilled beds may participate in both the skilled care program and the nursing facility program. These facilities shall not need to submit Form AA-4036-0. The facility's costs shall not be used to calculate the maximum nursing facility rate. The nursing facility rate for these facilities shall be the maximum as established in subrule 81.6(16) or their skilled care rate, whichever is lower.

81.6(17) *Nursing home reform rate adjustment.* Nursing facilities participating in the Iowa Medicaid program may submit a budget of anticipated new costs associated with meeting the Omnibus Reconciliation Act of 1987, nursing home reform requirements, to obtain a nursing home reform rate adjustment effective October 1, 1990.

a. In order to receive the rate adjustment, facilities shall submit the following information:

(1) A budget of anticipated new costs shall be submitted on Form 470-2722, OBRA Adjustment, which shall be comprised of a scheduling of direct care cost increases, such as nursing salaries and additional training or certification costs. The facilities shall also submit any additional OBRA costs and an explanation of each item. The cost estimates shall be those costs expected to occur during the period October 1, 1990, through March 31, 1991. The form shall be provided by the department and shall be subject to review by the accounting firm under contract with the department.

(2) Form AA-4036-0, Financial and Statistical Report for Nursing Facilities, shall be submitted within three months following the period ending September 30, 1990, which shall cover the period from July 1, 1990, through September 30, 1990. This special cost report will establish a cutoff date for pre-OBRA and post-OBRA costs.

(3) Form AA-4036-0 shall also be submitted within three months following the period ending March 31, 1991, covering the period October 1, 1990, through March 31, 1991.

b. New rates shall be established effective October 1, 1990, for facilities submitting the required reports based on actual reported costs plus the budgeted nursing home reform costs. Effective October 1, 1990, the maximum reimbursement rate for all nursing facilities shall be established at the seventy-fourth percentile of all facility costs based on cost reports on file June 30, 1990, and budgets on file August 31, 1990.

c. Nursing facility rates shall be adjusted effective April 1, 1991, based on the report of actual costs for the previous six-month period subject to the established maximum rate.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) "a," 249A.4, and 249A.16 and 1990 Iowa Acts, Senate File 2435, section 31, subsection 1.

441—81.7(249A) Continued review. The Iowa Foundation for Medical Care shall be responsible for reviews for need of continued care in nursing facilities.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.8(249A) Quality of care review. Rescinded IAB 8/8/90, effective 10/1/90.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents' personal records.

k. Residents' medical records.

l. Disaster preparedness reports.

81.9(2) Retention. Records shall be retained in the facility for a minimum of three years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A) or subrule 441—79.1(9). The per diem rate shall be no greater than the maximum reasonable cost determined by the department.

81.10(2) Authorization of payment. The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible.

81.10(3) Rescinded IAB 8/9/89, effective 10/1/89.

81.10(4) *Periods authorized for payment.*

- a.* Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.
- b.* Payment will be authorized as long as the resident is certified as needing care in a nursing facility.
- c.* Payment will be approved for the day of admission but not the day of discharge or death.
- d.* Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.
- e.* Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.
- f.* Payment for periods when residents are absent for visitation or hospitalization will be made at 75 percent of the allowable audited costs for those beds, not to exceed the maximum reimbursement rate.
- g.* Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.
- h.* Rescinded IAB 3/20/91, effective 3/1/91.

81.10(5) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

- a.* Supplies or services which the facility shall provide:
 - (1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.
 - (2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.
 - (3) Medical equipment and supplies including wheelchairs, sickroom supplies except for those listed in 441—78.10(4) “*b*,” oxygen except under circumstances specified in 441—78.10(2) “*a*,” and other items required in the facility-developed plan of care.
 - (4) Nonlegend drugs ordered by the physician except for those specified in 441—78.1(2) “*f*.”
 - (5) Fees charged by medical professionals for services requested by the facility which do not meet criteria for direct Medicaid payment.
- b.* The facility shall arrange for transportation to receive necessary medical services outside the facility. If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation.

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services which meet the Medicare definition of medical necessity and are provided by vendors enrolled in the Medicaid programs including:

- (1) Physician services.
- (2) Ambulance services.
- (3) Hospital services.
- (4) Hearing aids, braces and prosthetic devices.
- (5) Therapy services.

d. Other supplies or services for which direct Medicaid payment may be available include:

- (1) Legend drugs and nonlegend drugs specified in 441—78.1(2)“f.”
- (2) Dental services.
- (3) Optician and optometrist services.
- (4) Repair of medical equipment and appliances which belong to the resident.
- (5) Transportation to receive medical services outside the community subject to limitations specified in rule 441—78.13(249A).

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident spends over 18 days on yearly visitation (or longer under 81.10(4) “d”) or spends over ten days on a hospital stay. When the resident is not discharged from the facility, these payments shall not exceed 75 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserve bed in the same manner as a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not prescribe a nonlegend drug by brand name, the facility may offer a generic brand. If a resident or family member requests a brand name, the resident or family member may pay for the brand name nonlegend drug.

81.10(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

81.10(7) *Comparative charges between private pay and Medicaid residents.* The department shall not pay nursing facilities a per diem rate in excess of the average per diem rate charged to private pay residents.

a. The nursing facility shall recompute the average per diem rate on a facilitywide, private pay basis twice yearly. This computation shall coincide with the preparation of the financial and statistical report for nursing homes, Form AA-4036-0 which is submitted to the department.

b. An individual private pay resident’s rate shall be computed by accumulating the six months’ total charges for the individual and dividing the total charges by the total number of days in which the bed was occupied by or was being held for the resident. The total monthly charges will include the basic charge per day plus any standard charges for extra care and service.

c. To compute the facilitywide average private pay per diem rate, the facility shall accumulate total monthly changes for all private pay residents for the six-month period and divide by the total patient days for all private pay residents for the same period to arrive at the private pay average per diem rate for the entire facility.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)“a,” and 249A.4.

441—81.11(249A) Billing procedures.

81.11(1) Claims. Claims for service must be sent to the fiscal agent after the month of service and within 365 days of the date of service. Claims may be submitted electronically on software provided by the fiscal agent or in writing on Form AA-4163-0.

a. When payment is made, the facility will receive a copy of Form AA-4163-0, Payment Register. The right-hand copy of the original shall be returned to the department as a claim for the next month. If the claim is submitted electronically, the facility will receive a remittance statement of the claims paid.

b. When there has been a new admission, a discharge, a correction, or a claim for a reserved bed, the facility shall also submit Form AA-4164-0, Change Notice, with Form AA-4163-0. Adjustments to electronically submitted claims may be made electronically as provided for by the fiscal agent.

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) “a.”

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the local office of the department.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) “a.”

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication “State Operations Manual.”

a. The facility shall obtain the applicable license from the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Institutional Medicaid Provider Application, from the department.

c. The department shall transmit an application form and copies of standards to the facility.

d. The facility shall complete its portion of the application form and submit it to the department.

e. The department shall review the application form and forward it to the department of inspections and appeals.

f. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

k. Rescinded IAB 12/6/95, effective 2/1/96.

81.13(2) *Medicaid provider agreements.* The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

- a. Rescinded IAB 2/3/93, effective 4/1/93.
- b. Rescinded IAB 2/3/93, effective 4/1/93.
- c. Rescinded IAB 2/3/93, effective 4/1/93.
- d. Rescinded IAB 2/3/93, effective 4/1/93.
- e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.
- f. Rescinded IAB 2/3/93, effective 4/1/93.

81.13(3) *Distinct part requirement.* All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

- a. The distinct part shall meet the following conditions:
 - (1) The distinct part shall meet all requirements for a nursing facility.
 - (2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.
 - (3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.
 - (4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.
 - (5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) *Civil rights.* The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.
2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

- (8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

- (9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

- (1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

- (2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

- (3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. Free choice. The resident has the right to:

(1) Choose a personal attending physician.

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law.

f. Grievances. A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. *Examination of survey results.* A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. *Work.* The resident has the right to:

(1) Refuse to perform services for the facility.

(2) Perform services for the facility if the resident chooses, when:

1. The facility has documented the need or desire for work in the plan of care.

2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

3. Compensation for paid services is at or above prevailing rates.

4. The resident agrees to the work arrangement described in the plan of care.

5. Rescinded IAB 3/4/92, effective 4/8/92.

i. *Mail.* The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage and writing implements at the resident's own expense.

j. *Access and visitation rights.*

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.

2. Any representative of the state.

3. The resident's individual physician.

4. The state long-term care ombudsman.

5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.

6. The agency responsible for the protection and advocacy system for mentally ill individuals.

7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.

8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. *Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. *Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

81.13(6) Admission, transfer and discharge rights.

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

- (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

- (5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

- (6) Contents of the notice. The written notice shall including the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

- (7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

- b. Notice of bed-hold policy and readmission.*

- (1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

- (2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)“a”(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall:

1. Not require residents or potential residents to waive their rights to Medicare or Medicaid.

2. Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) *Resident behavior and facility practices.*

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. *Staff treatment of residents.* The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

*(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) *Quality of life.* A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

a. *Dignity.* The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

b. *Self-determination and participation.* The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. *Participation in resident and family groups.*

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. Comprehensive assessments.

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.
 2. Customary routine.
 3. Cognitive patterns.
 4. Communication.
 5. Vision.
 6. Mood and behavior patterns.
 7. Psychosocial well-being.
 8. Physical functioning and structural problems.
 9. Continence.
 10. Disease diagnoses and health conditions.
 11. Dental and nutritional status.
 12. Skin condition.
 13. Activity pursuit.
 14. Medications.
 15. Special treatments and procedures.
 16. Discharge potential.
 17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
 18. Documentation of participation in assessment.
 19. Additional specification relating to resident status as required in Section S of the MDS.
- (3) Frequency. Assessments shall be conducted:
1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
 2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.
 3. In no case less often than once every 12 months.
- (4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.
- (5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.
- (6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(7) Automated data processing requirement.

1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.

- Admission assessment.
- Annual assessment updates.
- Significant change in status assessments.
- Quarterly review assessments.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, if there is no admission assessment.

2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Health Care Financing Administration (HCFA) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the ASCII format specified by HCFA.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. *Accuracy of assessments.* The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.